

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005047	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/15/2014
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH BLOOMINGTON HOSF		STREET ADDRESS, CITY, STATE, ZIP CODE 601 W SECOND ST BLOOMINGTON, IN 47403		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>The visit was for the investigation of one (1) State complaint.</p> <p>Complaint number: IN00152653 Unsubstantiated; lack of sufficient evidence.</p> <p>Date of survey: 12/15/14</p> <p>Facility number: 005047</p> <p>Surveyor: Jennifer Hembree RN Public Health Nurse Surveyor</p> <p>Indiana University Health Bloomington is in compliance with 410 IAC 15-1.6-5 Psychiatric Services.</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE